DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 0 6

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.201, 447.252 through 447.272 and 447.302

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ -0-
b. FFY 2003 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, page 3.1
Attachment 4.19-B, pages 6G and 6H
Attachment 4.19-D, pages 8 - 15.2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, page 6G
Attachment 4.19-D, pages 8 - 15.2

10. SUBJECT OF AMENDMENT:
Allowable costs for Long Term Care, Federally Qualified Health Clinics, Rural Health Clinics and Hospitals

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review State Plan Amendments.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gail L. Margolis

14. TITLE:
Deputy Director

15. DATE SUBMITTED:
February 28, 2002

16. RETURN TO:
Department of Health Services
Attn: State Plan Coordinator
714 P Street, Room 1640
Sacramento, CA 95814

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: February 28, 2002

18. DATE APPROVED: April 5, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
August 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Linda Minamoto

22. TITLE: Associate Regional Administrator
Division of Medicaid

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

L. 1) Allowable costs, as that term is used in Section II.A.2, and elsewhere in this Attachment 4.19-A, shall not include provider expenditures to assist, promote,or deter union organizing to the extent such expenditures are paid by the provider with State funds. Definitions applicable to this paragraph L are set forth below in subparagraphs 2) and 3).

2) "Assist, promote, or deter union organizing" means any attempt by the provider to influence the decision of its employees in California, or the California employees of its subcontractors, regarding either of the following:

(a) Whether to support or oppose a labor organization that represents or seeks to represent employees.

(b) Whether to become a member of any labor organization.

3) "State funds" means California State Treasury funds or California State special or trust funds received by the provider on account of the provider's participation in a California state program. If State funds and other funds are commingled, any expenditures to assist, promote, or deter union organizing shall be allocated between State funds and other funds on a pro rata basis.

4) Any costs, including legal and consulting fees and salaries of supervisors and employees, incurred for research for, or preparation, planning, or coordination of, or carrying out, an activity to assist, promote, or deter union organizing shall be treated as paid or incurred for that activity.

5) To the extent the costs are not for expenditures to assist, promote, or deter union organizing, reasonable costs incurred are allowable for activities, such as:

(a) Addressing a grievance or negotiating or administering a collective bargaining agreement.

(b) Allowing a labor organization or its representatives access to the provider's facilities or property.

(c) Performing an activity required by federal or state law or by a collective bargaining agreement.

(d) Negotiating, entering into, or carrying out a voluntary recognition agreement with a labor organization.

payments the FQHC or RHC would have received under the methodology described in Section D or Section E.

(b) At the end of each FQHC's or RHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC or RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's or RHC's contract with MCEs would have yielded under the methodology described in Section D or Section E.

(c) If the amount received under the methodology described in Section D or Section E exceeds the total amount of supplemental and MCE payments, the FQHC or RHC will be paid the difference between the Section D or Section E amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC or RHC.

(d) If the amount calculated using the methodology described in Section D or Section E is less than the total amount of supplemental and MCE payments, the FQHC or RHC will refund the difference between the amount calculated using the methodology described in Section D or Section E (based on actual visits) and the total amount of supplemental and MCE payments received by the FQHC or RHC.

J. Payment for Services for Recipients with Medicare/Medi-Cal or Child Health and Disability Program (CHDP) Coverage

Where a recipient has coverage under the Medicare or the CHDP program, DHS will supplement the payment from those programs not to exceed the prospective payment rates established under this Supplement.

K. Limitations of Allowable Costs - State Funds

1. To the extent that any FQHC or RHC receives cost based reimbursement under subparagraphs (A) (2) or (F) (2), allowable costs shall not include provider expenditures to assist, promote, or deter union organizing to the extent such expenditures are paid by the provider with State funds. Definitions applicable to this paragraph I are set forth below in subparagraphs 2 and 3.

2. "Assist, promote, or deter union organizing" means any attempt by the provider to influence the decision of its employees in California, or the California employees of its subcontractors, regarding either of the following:

(a) Whether to support or oppose a labor organization that represents or seeks to represent employees.

(b) Whether to become a member of any labor organization.

3. "State funds" means California State Treasury funds or California State special or trust funds received by the provider on account of the provider's participation in a California state program. If State funds and other funds are commingled, any expenditures to assist, promote, or deter union organizing shall be allocated between State funds and other funds on a pro rata basis.

4. Any costs, including legal and consulting fees and salaries of supervisors and employees, incurred for research for, or preparation, planning, or coordination of, or carrying out, an activity to assist, promote, or deter union organizing shall be treated as paid or incurred for that activity.

5. To the extent the costs are not for expenditures to assist, promote, or deter union organizing, reasonable costs incurred are allowable for activities, such as:

   (a) Addressing a grievance or negotiating or administering a collective bargaining agreement.

   (b) Allowing a labor organization or its representatives access to the provider's facilities or property.

   (c) Performing an activity required by federal or state law or by a collective bargaining agreement.

   (d) Negotiating, entering into, or carrying out a voluntary recognition agreement with a labor organization.

3. For purposes of determining reasonable compensation of facility administrators, pursuant to Chapter 9 of the CMS Provider Reimbursement Manual (HIM 15) – reproduced in full at Paragraph 5577 of the CCH Medicare and Medicaid Guide, the State shall conduct its own survey. Based on the data collected from such surveys, the State shall develop compensation range tables for the purpose of evaluating facility administrator compensation during audits of those facilities.

   For purposes of this section, "facilities" are defined as: acute care, long term care (skilled nursing, intermediate care, intermediate care for the developmentally disabled, intermediate care for the developmentally disabled habilitative and nursing), Federally Qualified Health Centers, and Rural Health Clinics.

4. (a) Allowable costs shall not include provider expenditures to assist, promote, or deter union organizing to the extent such expenditures are paid by the provider with State funds. Definitions applicable to this paragraph 4 are set forth below in subparagraphs (b) and (c).

   (b) "Assist, promote, or deter union organizing" means any attempt by the provider to influence the decision of its employees in California, or the California employees of its subcontractors, regarding either of the following:

      (i) Whether to support or oppose a labor organization that represents or seeks to represent employees.

      (ii) Whether to become a member of any labor organization.

   (c) "State funds" means California State Treasury funds or California State special or trust funds received by the provider on account of the provider's participation in a California state program. If State funds and other funds are commingled, any expenditures to assist, promote, or deter union organizing shall be allocated between State funds and other funds on a pro rata basis.

   (d) Any costs, including legal and consulting fees and salaries of supervisors and employees, incurred for research for, or preparation, planning, or coordination of, or carrying out, an activity to assist, promote, or deter union organizing shall be treated as paid or incurred for that activity.

(e) To the extent the costs are not for expenditures to assist, promote, or deter union organizing, reasonable costs incurred are allowable for activities, such as:

(i) Addressing a grievance or negotiating or administering a collective bargaining agreement.

(ii) Allowing a labor organization or its representatives access to the provider's facilities or property.

(iii) Performing an activity required by federal or state law or by a collective bargaining agreement.

(iv) Negotiating, entering into, or carrying out a voluntary recognition agreement with a labor organization.

III. AUDITS

A. Except for DP/NFs, subacute, pediatric subacute, transitional inpatient care units, NF-As, ICF/DDs and state-operated facilities, a minimum of 15 percent of cost reports will be field audited by the Department each year. Facilities identified for audit shall be selected on a random sample basis, except where the entire universe of a class is selected for audit. Field audits may be restricted to facilities that have a complete year of reporting. The sample size for each shall be sufficiently large to reasonably expect, with 90 percent confidence, that it will produce a sample audit ratio which varies from the estimated class population audit ratio by not more than two percent. Other facilities may be audited as necessary to ensure program integrity. The results of federal audits, where reported to the State, may also be applied in determining the audit adjustment for the ongoing rate study.

B. The labor data reported by providers shall be audited. In the event that facilities are inconsistently reporting their labor costs in the OSHPD data, the Department will adjust the data utilized to develop the labor index so that the correct amount will be reflected. If the labor data used in developing the labor index is adjusted, the State Plan will be amended to provide the specific methodology for such adjustments.

C. Reports of audits shall be retained by the State for a period of not less than five years, in accordance with 42 CFR 433.32.

D. Providers will have the right to appeal findings which result in an adjustment to program reimbursement or reimbursement rates. Specific appeal procedures are contained in Section 14171 of the Welfare and

Institutions Code, and Article 1.5 (Provider Audit Appeals) of Title 22, California Code of Regulations. See Appendix 2.

E. When facilities being audited have more than one cost report with an end date in the audit year, the last report will be the one audited, except in those cases where a facility-specific audit adjustment will be applied or actual audited costs are used. In these cases, all cost reports with an end date in the audit year will be audited.

F. All state-operated facilities will be subject to annual audits.

G. Cost reports for nursing facilities that are distinct parts of acute care hospitals may be audited annually.

H. All subacute and pediatric subacute providers will be subject to annual audits.

I. All transitional inpatient care units may be subject to annual audits.

IV. PRIMARY REIMBURSEMENT RATE METHODOLOGY

Reimbursement rates shall be reviewed by the Department at least annually. Prospective rates for each class shall be developed on the basis of cost reports submitted by facilities. The following method shall be used to determine rates of reimbursement for a class of facilities when cost reports are available:

A. Audit Adjustment.

1. An audit adjustment shall be determined for each of the following classes:

   (a) NF level B field audited facilities with 1-59 beds.
   (b) NF level A field audited facilities with 1-99 beds.
   (c) NF level B field audited facilities with 60+ beds.
   (d) NF level A field audited facilities with 100+ beds.
   (e) ICF/DD field audited facilities with 1-59 beds.
   (f) ICF/DD field audited facilities with 60+ beds.
   (g) ICF/DD-H field audited facilities with combined bedsizes.
   (h) ICF/DD-N field audited facilities with combined bedsizes.

2. Except for DP/NFs and subacute providers, where the audit sample exceeds 80 percent of the universe in a class, the audit adjustment will be applied on a facility-specific basis except that the: (1) class average will be used for unaudited facilities and (2) actual audited costs will be used when the fiscal period of the field audit agrees with the fiscal period of the cost report used in the study.

3. For DP/NFs and subacute providers, actual audited costs will be used to determine the facility's prospective rate when the fiscal period of the field audit agrees with the fiscal period of the cost report used in the study. If the field audit of the cost report used in the study is not available by July 1, then an interim rate shall be established by applying the field audit adjustment of the NF level Bs with 60+ beds to the cost report. If a facility has an interim reimbursement rate, when the audit report that matches the cost report is issued or the cost report is deemed true and correct under W&I Code Section 14170(a)(1), the Department shall adjust the facility's projected reimbursement rate retroactively to the beginning of the rate year to reflect these costs, not to exceed the maximum rate as set forth in Section IV.E. Interest shall accrue and be payable on any underpayments or overpayments resulting from such adjustment. Medicare standards and principles of cost reimbursement shall be applied when auditing DP/NFs (see 42 CFR Part 413).

4. As a result of the appeal process mentioned in III.D., some audit findings may be revised. Except for DP/NFs and subacute, the audit adjustment for the current year shall incorporate any revisions resulting from a decision on an audit appeal. The Department shall consider only the findings of audit appeal reports that are issued more than 180 days prior to the beginning of the new rate year.

   For DP/NFs or subacute providers, excluding pediatric subacute, that obtain an audit appeal decision that the facility-specific audit adjustment on which a DP/NF or subacute rate is based inaccurately reflects the facility's projected costs, the facility shall be entitled to seek a retroactive adjustment in their prospective reimbursement rate, not to exceed the maximum DP/NF or subacute rate, as set forth under Section IV (E)(1), (10) and (11).

5. Audited costs will be modified by a factor reflecting share-of-cost overpayments in the case of class audit adjustments.

6. The results of federal audits, when reported to the state, may be applied in determining audit adjustments.

B. Adjustment for facilities which provide a different type of service from the remainder of the class.

Additional amounts, where appropriate, shall be added to the payment rates of individual facilities in a class to reimburse the costs of meeting

requirements of state or federal laws or regulations including the costs of special programs.

C. Change in service provided since cost report period.

Adjustments to reported costs of facilities will be made to reflect changes in state or federal laws and regulations which would impact upon such costs. These adjustments will be reflected as an "add-on" to the rates for these costs and, where appropriate, an "add-on" may be used to reflect other extraordinary costs experienced by providers. "Add-ons" to the rate may continue until such time as those costs are included in cost reports used to set rates under this state plan.

For example, state or federal mandates may include such costs as changes to the minimum wage or increases in nurse staffing requirements. An example of other extraordinary costs might include unexpected increases in workers compensation costs or other costs which would impact facilities' ability to continue to provide patient care.

A brief description of all add-ons included in the current year's rate study will be provided to CMS by December 31st of the rate year.

D. Updates.

Updates to reported costs will reflect economic conditions of the industry. The following economic indicators will be considered where the Department has not developed other indicators of cost:

1. California Consumer Price Index, as determined by the State Department of Finance.
2. An index developed from the most recent historical data in the long term care industry as reported to OSHPD by providers.

The update factors used by the Department shall be applied to all classes from the midpoint of each facility's fiscal period to the midpoint of the State's rate year in which the rates are effective.

E. Cost-of-Living Update

Adjusted costs for each facility are updated from the midpoint of the facility's report period through the midpoint of the State's Medi-Cal rate year.

Adjusted costs are divided into categories and treated as follows:

1. Fixed or Capital-Related Costs - These costs represent depreciation, leases and rentals, interest, leasehold improvements, and other amortization. No update is applied.

2. Property Taxes - These costs, where identified, are updated at a rate of 2 percent annually, converted to 0.1652 percent per month. Some facilities do not report property taxes---either because they are nonprofit and exempt from such tax or because they have a lease or rental agreement that includes those costs.

3. Labor Costs - A ratio of salary, wage, and benefits (SWB) costs to the total costs of each facility is used to determine the amount of the labor cost component to be updated. The ratio is determined by using the overall ratio of salaries and wages to total costs from data extracted by OSHPD from the labor report, and adding costs that represent all wage-related benefits, including vacation and sick leave.

   The labor costs for ICF/DD-Hs and ICF/DD-Ns are facility-specific, obtained directly from each cost report in the study. Labor costs for each facility are updated from the midpoint of its cost reporting period to the midpoint of the State's rate year.

4. All Other Costs - These costs are the total costs less fixed or capital-related costs, property taxes, and labor costs. The update for this category utilizes the California Consumer Price Index (CCPI) for "All-Urban Consumers" and figures projected by the State Department of Finance.

F. The reimbursement rate per patient day shall be set at the median of projected costs for the class, as determined above, except that:

1. NF-B services, excluding subacute and pediatric subacute, which are provided in distinct parts of acute care hospitals, shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate.

2. NF-A services provided in distinct parts of acute care hospitals shall be reimbursed at the applicable NF-A rate for freestanding facilities in the same geographical area location.

3. Rural hospitals are identified each year by OSHPD. For those rural hospitals with Medi-Cal distinct part nursing facility days, their rates, as determined for the DP/NF-B level of care, are arrayed and the median rate is applied to all rural swing bed days. Facilities that report no Medi-Cal days, have an interim rate, or

submit only a partial year cost report are excluded from the swing bed rate calculation.

4. NF services provided in a facility which is licensed together with an acute care hospital under a single consolidated license, yet fails to meet the definition of a DP/NF, shall be reimbursed at the applicable rate for freestanding facilities.

5. As long as there is a projected net increase in the California Consumer Price Index during the State's fiscal year previous to the new rate year, no prospective rate of reimbursement shall be decreased solely because the class median projected cost is less than the existing rate of reimbursement. In the event the existing prospective class median is adopted as the maximum reimbursement rate for DP/NF-Bs and subacute units providers with projected costs below the existing class median shall be reimbursed their projected costs as determined in the most recent rate study.

   In the event there are components in the previous rate study that increased the reimbursement rate to compensate for time periods prior to the effective date of the rates, the rates shall be adjusted (for purposes of determining the existing rate) to reflect the actual per diem cost without the additional compensation. As an example, assume that the per diem cost of a new mandate was $.10. The new mandate was effective June 1, 1997, but the rates were not implemented until August 1, 1997. The rates would include an add-on of $.117 ($.10 times 14 months, divided by 12 months) to compensate 14 months add-on over a 12 month rate period.

6. If a DP, formerly licensed as a freestanding facility, has costs less than the freestanding median rate for their group, their rate will not be reduced to less than the median solely because of the change to distinct part licensure.

7. DPs in areas where there are excess freestanding beds may accept patients at the area's highest NF-B rate to assure greater access to Medi-Cal patients and to provide a savings to the program.

8. State operated facilities shall be reimbursed their costs as reflected in their cost reports, in accordance with the provisions of this plan, using individual audit data for adjustments. These costs are not to be included in the calculation of the class median rate for all other DP/NF level Bs.

9. ICF/DDs (except state operated facilities), ICF/DD-H and ICF/DD-N facilities will be reimbursed at the 65th percentile, instead of the median, in recognition of the fact that they serve a disproportionate share of low income patients with special needs.

10. Subacute services which are provided in both distinct parts of acute care hospitals and freestanding NFs shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate, broken down by ventilator and non-ventilator and DP or freestanding NF.

11. The subacute rate includes additional ancillary costs. Where available, the facility's projected cost is based on the audited ancillary cost data. In the event that audited ancillary costs are not available, the facility's projected cost is based on the median of the projected subacute ancillary costs of the facilities in the study that have audited ancillary costs.

12. For purposes of setting the DP/NF or subacute prospective class median rate, the Department shall use the facility's interim projected reimbursement rate when their audit report is not issued as of July 1st.

13. Transitional inpatient care is reimbursed based on a model rate in accordance with Section V.A. of this Attachment.

14. Each year the current rate for NF-A 100+ bedsize will be increased by the same percentage of increase received by other NF-level As. The term percentage increase means the average increase, weighted by patient days.

15. (a) Nursing facilities and other specified facilities as identified in Section 14110.65 of the Welfare and Institutions Code, will be eligible to request and receive a supplemental rate adjustment when the facility meets specific requirements.

(b) In order to qualify for the rate adjustment, the facility must have a verifiable written collective bargaining agreement or other legally binding, written commitment to increase non-managerial, non-administrative and non-contract salaries, wages and/or benefits that complies with Section 14110.65 of the Welfare and Institutions Code and regulations adopted pursuant thereto.

(c) Except as provided in subparagraph (d) below, the rate adjustment will be equal to the Medi-Cal portion (based on the proportion of Medi-Cal paid days) of the total amount of any

increase in salaries, wages and benefits provided in the enforceable written agreement referenced in subparagraph (b). This amount will be reduced by an increase, if any, provided to that facility during that rate year in the standardized rate methodology for labor related costs (see Section I.E of this state plan) attributable to the employees covered by the commitment. A rate adjustment made to a particular facility pursuant to this subparagraph 15 will only be paid for the period of the non-expired, enforceable, written agreement. The Department will terminate the rate adjustment for a specific facility if it finds the binding written commitment has expired and does not otherwise remain enforceable.

(d) A rate adjustment under this subparagraph 15 will be no more than the greater of 8 percent of that portion of the facility's per diem labor costs, prior to the particular rate year (August 1st through July 31st), attributable to employees covered by the written commitment, or 8 percent of the per diem labor costs of the peer group to which the facility belongs, multiplied by the percentage of the facility's per diem labor costs attributable to employees covered by the written commitment.

(e) The payment of the rate adjustment will be subject to certification of the availability of funds by the State Department of Finance by May 15 of each year and subject to appropriation of such funds in the State's Budget Act.

(f) This subparagraph 15 will become effective as of the first day of the month following the date that this provision is approved by the Centers for Medicare and Medicaid Services.

G. Notwithstanding paragraphs A through E of this Section, prospective rates for newly licensed DP/NF-Bs shall be based on the facility's historical costs of providing NF-B services regardless of ownership or licensure.

For DP/NF-Bs with historical costs as a licensed freestanding NF-B, the Department shall establish a prospective DP/NF-B rate based on the freestanding NF-B cost report. If the newly licensed DP/NF-B has reported costs as both a freestanding NF-B and DP/NF-B, the Department shall establish the facility's historical-costs basis by combining the freestanding NF-B and DP/NF-B total patient days and costs. Newly licensed DP/NF-Bs shall receive prospective rates based on available freestanding NF-B cost reports until the Department uses the consolidated hospital DP/NF-B cost report and/or audit in the appropriate rate study.

Newly licensed DP/NF-Bs without historical costs of providing NF-B services shall receive an interim reimbursement rate. This interim rate

shall be based on the DP/NF-B's projection of their total patient days and costs, as approved by the Department. When actual DP/NF-B audit report data becomes available, interim rates will be retroactively adjusted to the DP/NF-Bs final prospective rate. Final DP/NF-B rates may be less than the interim rate, in which case the Department shall recover any overpayment.

H. Subacute providers that do not have historical costs shall receive an interim reimbursement rate. This interim rate shall be based on the subacute facility's projection of their total patient days and costs, as approved by the Department. When actual subacute audit report data becomes available, interim rates will be retroactively adjusted to the subacute facility's final prospective rate. Final rates may be less than the interim rate, in which case the Department shall recover any overpayment. Only subacute providers participating in the program as of June 1st will be included in the rate study.

V. DETERMINATION OF RATES FOR NEW OR REVISED PROGRAMS

A. When the State adopts a new service or significantly revises an existing service, the rate of reimbursement shall be based upon comparable and appropriate cost information which is available. Comparable rate and cost data shall be selected and combined in such a manner that the rate is reasonably expected to approximate median audited facility costs, had accurate cost reports been available for the particular class of facility. Such factors as mandated staffing levels and salary levels in comparable facilities shall be taken into account. This method of rate-setting shall ordinarily be relied upon to set rates only until such time as accurate cost reports which are representative of ongoing operations become available.

B. When it is determined that cost report data from a class of facilities is not reliable for rate-setting purposes due to inaccuracies or reporting errors, a random sample of such facilities shall be selected for audit and the resulting audited costs shall be used for the rate study.

C. After five years from the end of the fiscal year in which a facility begins participating in a program for Medi-Cal reimbursement, the reimbursement rate methodology will either revert to the provisions described in Section I through IV of Attachment 4.19-D or be subject to new provisions as described in a State Plan amendment.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
San Francisco Regional Office
75 Hawthorne St., Suite 408
San Francisco, CA 94105

APR - 5 2002

Gail L. Margolis, Deputy Director
Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, CA 95814

Dear Ms. Margolis:

Enclosed is a copy of California State plan amendment (SPA) No. 02-006, which we have approved effective August 1, 2002. This SPA clarifies what may be included as allowable costs for long term care, FQHCs/RHCs, and hospitals. Allowable costs may not include expenditures to assist, promote, or deter union organizing to the extent that such expenditures are paid by the provider with State funds.

Questions concerning this approval should be directed to Pat Daley at (415) 744-3592.

Sincerely,

Susan Weatherly for

Linda Minamoto
Associate Regional Administrator
Division of Medicaid

Enclosure

cc: Elliott Weisman, CMS, Center for Medicaid and State Operations
Suzan Stecklein, CMS, Center for Medicaid and State Operations
Robert Weaver, CMS, Center for Medicaid and State Operations
Barbara Hardiman, DHS, California State Plan Coordinator